BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)24 and 25

AND

ROBERT FYFE (01-31612)

DETERMINATION OF A SUBSTANTIVE HEARING
CONDUCTED REMOTELY 04 – 12 DECEMBER 2023

Committee Members:	Mr James Kellock (Chair/Lay) Mr Ben Summerskill (Lay) Mr Nigel Pilkington (Lay) Mr David Cartwright (Optometrist) Ms Kalpana Theophilus (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Ms Aaminah Khan
GOC Presenting Officer:	Mr Matthew Corrie
Registrant present/represented:	No and not represented
Registrant representative:	None
Hearings Officer:	Ms Arjeta Shabani
Facts found proved:	Matter 1 (2022/085) particulars 1, 3 a) - c) Matter 2 (2022/088) particulars 1a), c), d), 2 a) – d), 4 and 5
Facts not found proved:	Matter 1 (2022/085) particular 2 Matter 2 (2022/088) particulars 1 b)
Misconduct:	Found
Impairment:	Impaired
Sanction:	Erasure
Immediate order:	Immediate suspension order imposed

Proof of service

1. As the Registrant did not attend the hearing, nor was he represented, the Committee heard an application from Mr Corrie, on behalf of the Council, for the matter to proceed in the Registrant's absence. First, the Council was required to satisfy the Committee that the documents had been served in accordance with Section 23A of the Opticians Act 1989 and Rule 61 of the General Optical Council (Fitness to Practise) Rules 2013 ('the Rules'). The Committee had before it a service bundle, containing documentation relating to the service of the Notice of Hearing.

2. Mr Corrie referred the Committee to the Notice of Hearing, dated 20 October 2023, which contained the details of the hearing starting today. Mr Corrie highlighted that the Notice of Hearing had been emailed to the Registrant's registered email address, which he had previously consented to being used for correspondence with the Council. Further, the Notice of Hearing was emailed to the Registrant's then representatives, the Association of Optometrists ('AOP').

3. Mr Corrie took the Committee through more recent correspondence from the Council to the Registrant, relating to a Procedural Hearing, which took place on 17 November 2023. In this recent correspondence, in an email dated 7 November 2023, the AOP had advised that the Registrant had decided to voluntarily absent himself from these proceedings, and that the Registrant fully understood that the matter will proceed in his absence.

4. Mr Corrie invited the Committee to find from the correspondence with the Registrant that there had been good service in accordance with the Rules.

5. The Committee accepted the advice of the Legal Adviser, who referred the Committee to the Rules on service of the Notice of Hearing, the requirement that at least 28 days notice should be given for a substantive hearing and acceptable methods of service.

6. The Committee had regard to the documentation before it regarding service contained within the service bundle. The Committee noted that the Registrant had been served with the Notice of Hearing over 28 days ago, on 20 October 2023, which was sent to an email address that the Registrant had registered with the Council. The Committee further noted that the Registrant had previously confirmed in an email to the Council on 20 April 2022 that he was content to receive notices from the Council via email.

7. The Committee noted that the Registrant's then representatives, the AOP, had also been sent the Notice of Hearing and had subsequently confirmed, in their email dated 7 November 2023, that the Registrant '*has decided to voluntarily absent himself from these proceedings and will not take any*

further part in this process…or the substantive hearing. He fully understands that the matter will proceed in his absence.'

8. The Committee was satisfied, in the circumstances, that there had been effective service of the Notice of Hearing and that all reasonable efforts had been made to notify the Registrant of the hearing, in accordance with the Rules.

Proceeding in the absence of the Registrant

9. The Committee then went on to consider whether it would be in the public interest to proceed in the Registrant's absence in accordance with Rule 22, which states that:

> **"*Proceeding in the absence etc. of the registrant***
>
> *22. Where the registrant is neither present nor represented at a hearing, the Fitness to Practise Committee may nevertheless proceed if—*
> *(a) it is satisfied that all reasonable efforts have been made to notify the registrant of the hearing in accordance with section 23A(a) and rule 61; and*
> *(b) having regard to any reasons for absence which have been provided by the registrant, it is satisfied that it is in the public interest to proceed."*

10. Mr Corrie, on behalf of the Council, submitted that it was in the public interest to proceed in the absence of the Registrant, highlighting in particular the following reasons:

    i) The Council had complied with their obligations to inform the Registrant of the hearing;
    ii) The Registrant had, via his former representatives the AOP, indicated that he had voluntarily absented himself from these proceedings and understood that the matter would proceed in his absence;
    iii) There was no positive application for an adjournment, no grounds for such an application and, in any event, no indication that the Registrant would attend a future hearing if the case was adjourned;
    iv) The Registrant has been given the knowledge and means to join this hearing but has chosen not to do so, waiving his right to attend;
    v) It is in the public interest that regulatory proceedings take place expeditiously, given the scarce and precious resources that are allocated to the hearing and that witnesses are available to attend this week.

11. Mr Corrie confirmed that the Registrant had not provided any reason for his absence, other than the statement (and similar ones in other correspondence not before the Committee) that he was voluntarily absenting himself. Mr

Corrie invited the Committee to determine that it was in the public interest to proceed in the Registrant's absence.

12. The Committee accepted the advice of the Legal Adviser, who referred the Committee to the guidance on proceeding in a Registrant's absence in the Council's 'Hearings and Indicative Sanctions Guidance' (updated November 2021)('the Guidance'). She referred the Committee to the cases of *R v Jones* [2002] UKHL and *General Medical Council v Adeogba* [2016] EWCA Civ 162, which outlined the principles to apply when considering an application to proceed in absence. The Legal Adviser advised that the Committee had a discretion as to whether to proceed in absence, which should be exercised with great care. The Committee should have regard to any reasons for absence which have been provided by the Registrant, and consider, whether in the circumstances, it is in the public interest to proceed. The Legal Adviser advised the Committee that it should take into account the public interest in the hearing of cases in a timely and fair manner and if a decision was made to proceed in absence, this did not need to be reviewed at future stages of the hearing.

13. The Committee was of the view that although the reasons for the Registrant's absence were not entirely clear, it was satisfied that the Registrant was fully aware of today's hearing and he had voluntarily absented himself. Further, from the email sent by the AOP, dated 7 November 2023, the Registrant was fully aware that the hearing could proceed in his absence and by disengaging, he had voluntarily waived his right to attend. There was no application to adjourn by the Registrant. In the circumstances, the Committee could not see any basis for not proceeding today and there would be nothing gained by adjourning the hearing, as there was nothing to reassure the Committee that the Registrant would attend a future hearing. These were serious allegations which had been ongoing for some time and it was in the public interest to determine them without undue delay.

14. Accordingly, the Committee determined that it would be in the public interest for the hearing to proceed in the Registrant's absence.

Preliminary Issue

15. At the outset of the hearing, it was raised by the Chair of the Committee that several of the Committee members had responded to a conflict check to declare that they were aware of, or had a professional connection with, the Council's expert witness Dr Anna Kwartz. The Chair invited the Committee members to describe the connection, if any, they had with Dr Kwartz.

16. Both Optometrist members of the Committee indicated that they were professionally acquainted with Dr Kwartz, in that they and Dr Kwartz were examiners for the College of Optometrists and if examining at the same time, they will have attended briefings together. However, this role did not involve them directly working together, as the examinations themselves were carried out in isolation.

17. Mr Cartwright confirmed that he had not acted as an examiner with Dr Kwartz for several years. In addition, he had also sat in two or three past Fitness to Practise Committee ('FTPC') cases where Dr Kwartz had given evidence as an expert witness. Ms Theophilus stated that she had worked in the examiner's role as recently as October 2023 and may have been in a short briefing with Dr Kwartz and others, but there had been no personal exchanges between herself and Dr Kwartz. Ms Theophilus could not recall if she had heard Dr Kwartz give expert evidence before.

18. Mr Kellock, the Committee Chair, declared that he had come across Dr Kwartz as an expert witness in his role on the Council's Investigation Committee, when he would see Dr Kwartz's written expert reports, and he had also sat on a FTPC substantive hearing a few weeks ago, where she had been an expert witness for the Council. Mr Pilkington and Mr Summerskill had no recollection of whether they had sat on a case before where Dr Kwartz had been an expert witness.

19. Mr Corrie reminded the Committee that the test for considering whether there was a conflict, which may require a member to recuse themselves, was that as set out in *Porter v Magill* [2002] 2 AC 357, namely whether the circumstances would lead a fair-minded and informed observer to conclude that there was a real possibility of bias. He confirmed that having considered this matter, the Council had no issues with any members of the panel remaining as a member of the Committee and hearing this case, as the Council considered that the connections declared with Dr Kwartz were too distant to give cause for concern. Mr Corrie submitted that simply having heard expert evidence from Dr Kwartz previously was not considered by the Council to be an issue, as this was likely to arise when an expert regularly gives evidence before a regulatory tribunal and this would not of itself give rise to actual or perceived bias.

20. Mr Corrie submitted that in relation to the connections declared by the Optometrist members of the Committee, the Council would wish to enquire as to whether either Optometrist member considered that this would have any impact upon their ability to fairly and objectively determine the issues in the case. Following both Optometrist members confirming that it did not have any such impact, Mr Corrie submitted that there was no basis for any of the members of the panel to recuse themselves. Mr Corrie confirmed in response to questions from the Chair, that the Registrant had been informed of the members of the Committee and that he had not raised any issues regarding the constitution of the Committee himself.

21. The Committee accepted the legal advice given by the Legal Adviser, which was the test in *Porter v Magill*, as outlined by Mr Corrie, was the correct test to apply in these circumstances and the decision as to recusal was one for the whole Committee, rather than individual members. Further, when considering the fair-minded observer, they had been described in caselaw as '*neither complacent, nor unduly suspicious*' (as per *Belize Bank Limited v Attorney General of Belize* [2011] UKPC 36).

22. The Committee considered the position in respect of potential bias and conflict in relation to each Committee member separately. The Committee noted the Council's position that it considered that the connections declared were too remote for a fair-minded and informed member of the public to conclude that there was a real possibility of bias.

23. Whilst the Optometrist members had a slightly more involved connection with Dr Kwartz, in that they were also examiners, as Dr Kwartz was, these interactions were fleeting and it was more a case of them being familiar with Dr Kwartz's name. No member of the Committee had declared any personal connection with Dr Kwartz and all members of the Committee were content to continue to hear the case.

24. In the circumstances, considering the test in *Porter v Magill*, the Committee concluded that there was no basis for actual nor perceived bias and there was no basis for any Committee member to be unable to decide the case impartially and fairly. The Committee did not consider that the test in *Porter v Magill* was met in respect of any member, and that there was no basis for any member of the Committee to recuse themselves. Accordingly, the Committee determined to continue to hear the case as originally constituted.

ALLEGATION (AS AMENDED)

Matter 1 – 2022/085

The Council alleges that you, Robert Fyfe, a registered optometrist, whilst working at [redacted]:

1. *On or around 25 August 2020 you failed to send the vision report from the sight test conducted on Patient A on 25 August 2020 to the [redacted] Royal Infirmary; and/or*

2. *On or around 14 November 2021, on a referral, you misdiagnosed Patient A with esotropia; and/or*

3. *You failed to make any, or any adequate, clinical record of:*

a. the sight test conducted on Patient A on or around 25 August 2020 and/or
b. the sight test conducted on Patient A on or around 9 July 2021; and/or
c. the pre-cataract surgery assessment you carried out on Patient A on 10 August 2021.

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

Matter 2 – 2022/088

The Council alleges that you, Robert Fyfe, a registered optometrist, whilst working at [redacted]:

1. *On or around 8 March 2022 you failed to record details about Patient B's symptoms in relation to:*

a. History and/or
b. Character of the symptoms and/or
c. Duration of the symptoms and/or
d. Onset of the symptoms

2. *On or around 8 March 2022 you failed to conduct an adequate sight test on Patient B in that you:*

a. Failed to undertake Patient B's levels of acuity, and/or
b. Failed to check for relative afferent pupil defects, and/or
c. Failed to conduct a pinhole examination, and/or
d. Failed to detect signs of Patient B's swollen right optic nerve

3. *In the alternative to 2) above on or around 8 March 2022 you failed to make an adequate record of the sight test conducted on Patient B in that you:*

a. Failed to record Patient B's levels of acuity, and/or
b. Failed to record relative afferent pupil defects, and/or
c. Failed to record a pinhole examination, and/or
d. Failed to record signs of Patient A's (SIC – Patient B) swollen right optic nerve.

4. *You failed to urgently refer Patient B to a hospital eye service for further investigation of their symptoms when it was indicated to do so.*

5) You misdiagnosed Patient B with suspected pigment epithelial detachment.

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

DETERMINATION

Admissions in relation to the particulars of the allegation

25. As the Registrant was not present, nor represented, there were no admissions made to the Allegation.

26. Mr Corrie confirmed that whilst the Registrant had made some admissions in his correspondence with the Case Examiners, the Council was not inviting the Committee to find any matters proved on the basis of those admissions, given that the Registrant was not present to confirm them. Rather, the Council will invite the Committee to give those admissions appropriate weight at the end of the facts stage.

Background to the allegations

27. The Registrant is an Optometrist who first registered with the Council on 11 June 1976. At the time of the events giving rise to the allegations, the Registrant was a director and Optometrist at [redacted] opticians, located in [redacted]. The Registrant faces allegations relating to clinical concerns and record-keeping failures, arising from his examination of two longstanding patients of his, Patients A and B.

28. In relation to matter one, in autumn 2018, Patient A was examined by the Registrant and diagnosed with bilateral cataracts, as a result of which Patient A was referred by the Registrant to [redacted] Royal Infirmary. Following a hospital assessment in June 2019, Patient A was informed that his cataracts were not at an advanced stage and Patient A decided not to proceed with surgery at that time.

29. Patient A had a further eye examination with the Registrant in December 2019, when Patient A informed the Registrant that he had not gone ahead with the cataract surgery.

30. In the summer of 2020, Patient A felt that his eyesight was worsening and he requested that his GP re-refer him to the Infirmary for the cataract surgery. Patient A was then contacted by the Infirmary and advised that he needed to have an up to date visual assessment. Patient A made an appointment with the Registrant in order to have this visual assessment carried out.

31. The appointment took place on 25 August 2020 and it is the Council's case that Patient A made clear to the Registrant that he was attending that appointment because he required an up to date visual assessment, in order to send to [redacted] Royal Infirmary. Patient A's evidence was that he left that appointment with the impression that the Registrant would be sending the visual assessment to the Infirmary, as requested.

32. When Patient A had not heard any further regarding his surgery, he contacted the Infirmary in the summer of 2021 and was informed that he was not yet on the waiting list as they were still waiting to receive the up to date visual assessment report. Patient A contacted the Registrant regarding this

and the Registrant informed him that he had not sent the visual assessment report following the appointment on 25 August 2020, as his practice was private and did not refer patients to the NHS.

33. On 9 July 2021, Patient A attended [redacted] again for a further vision report to be obtained and provided to Patient A. Patient A provided this report to the Infirmary and arrangements were made for progression to surgery on the NHS.

34. Patient A complained to [redacted] regarding the failure to send the visual assessment report to the Infirmary in August 2020 and other matters. In response, Mr Fyfe offered Patient A cataract surgery, to be carried out at [redacted], free of charge.

35. Patient A subsequently attended a pre-cataract surgery assessment with the Registrant on 10 August 2021 and attended for surgery on 11 November 2021. On the day of the planned surgery, the operation was cancelled by the surgeon, Mr H (there were different spellings within the papers), after he detected the presence of ptosis (droopy eyelids) and exotropia (outward facing squint).

36. On 14 November 2021, the Registrant sent an email referral regarding Patient A, which referred to Patient A having 'esoptropia' [sic] (esotropia is an inward facing squint), which was incorrect and a mis-diagnosis. It was the Council's case that the fact that Patient A had exotropia was already documented in Patient A's patient records, on the note of the consultation on 11 November 2021.

37. Part of the Allegation relates to alleged failures in the Registrant's recordkeeping, in that no, or no adequate, clinical record was made by the Registrant, in respect of the appointments with Patient A on 25 August 2020, 9 July 2021 and the pre-cataract surgery assessment on 10 August 2021. The Council allege that from the patient records provided to them by the Registrant, it is not at all clear what examination or treatment took place on each date. In some instances, there was no record and, in some instances, the Council say it was clearly inadequate.

38. In relation to matter two, involving Patient B, this part of the Allegation concerns an appointment on 8 March 2022. Patient B had previously had laser eye surgery carried out by [redacted]. Following a deterioration in vision, intraocular lens replacement surgery on both eyes was carried out at the practice in June and September 2021 respectively. Patient B attended further appointments at [redacted] in November 2021, January 2022 and February 2022, as she was concerned that her near vision had worsened.

39. On 4 March 2022, Patient B lost all vision in her right eye and called [redacted] on 7 March 2022 to make an appointment. She was seen by the Registrant on 8 March 2022. Patient B's recollection, as set out in her witness statement, was that she was told by the Registrant that she had a detached retina and that she would need to see the Ophthalmologist at [redacted] four days later. Later that day, Patient B mentioned this in passing

to a pharmacist, who was concerned regarding the possibility of a detached retina, which is an emergency condition. The pharmacist obtained a further eye examination for Patient B later that day, with Witness A of [redacted] Opticians.

40. At that appointment, Witness A observed a significantly swollen optic nerve in Patient B's right eye, with some haemorrhaging around the swollen nerve. He made an urgent referral for Patient B to the Infirmary, where the next day, the diagnosis of a swollen right optic disc was confirmed. Upon further tests, on 28 April 2022, a working diagnosis of neuro-retinitis was made.

41. The failures alleged in respect of Patient B relate to the Registrant's alleged failure to record details of Patient B's symptoms, failing to conduct an adequate sight test on Patient B on 8 March 2022 and/or to adequately record details of the same, an alleged failure to urgently refer Patient B to the hospital eye service ('HES') when indicated and misdiagnosing her with suspected pigment epithelial detachment ('PED').

42. The Registrant in correspondence with the Council stated that he believed that Patient B's symptom of loss of vision was due to underlying PED and in submissions to the Case Examiners, the Registrant submitted that there was no duty on Optometrists to make a diagnosis in any event.

The hearing

43. The Committee heard oral evidence from the Council's witnesses Witness A, Patient A and the expert witness Dr Anna Kwartz, who all attended the hearing remotely and were questioned by Mr Corrie, on behalf of the Council, and the Committee.

44. The Committee did not hear oral evidence from Patient B, whose witness statement dated 16 May 2022 was admitted as hearsay evidence, following the Council's application to admit it, which was granted at the Procedural Hearing on 17 November 2023.

45. The Committee had before it a bundle of documentary evidence, which included but was not limited to, patient records for Patients A and B, correspondence with the Registrant and the expert reports of Dr Anna Kwartz, dated 20 January 2023 and 18 September 2023, in relation to Patient A and dated 3 November 2022 and 18 September 2023, in relation to Patient B.

46. At the end of the Council's case and before making closing submissions, Mr Corrie made an application to amend the Allegation under Rule 46(20), which is in the following terms:

"*(20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*

(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and

(b) *the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms*."

47. Mr Corrie applied to remove the words '*letter signed by you*' from particular 2 of the Allegation for matter 1 (2022/085), on the basis that having considered the evidence in the case, the referral in question was in an email, not a letter, and also it was not signed by the Registrant. Mr Corrie submitted that it would be contrary to the interests of the wider public if the Committee, being satisfied that there was a misdiagnosis, acquitted the Registrant on a technicality because these aspects of the original Allegation were inaccurate.

48. Mr Corrie submitted that the application to remove these words, to make the wording of the Allegation more accurate, would not cause any prejudice to the Registrant, as the nature of the mischief alleged, namely the misdiagnosis, remained the same. He submitted that it was an amendment of form, rather than substance. Mr Corrie submitted that if the amendment was not to be made, there could be prejudice to the Council and the wider public, as this could prevent this particular of the Allegation being found proved.

49. In relation to the amendment application, the Legal Adviser advised that the Committee had a discretion under Rule 46(20) to make amendments, at any stage of the hearing, either on an application by a party or of its own motion, if satisfied that the amendment can be made without injustice and that issues of prejudice and fairness had to be considered from both parties' perspectives and the interests of justice. Whilst ordinarily both parties would be invited to make representations on such an application, by the Registrant having decided not to attend he had lost the opportunity to do so. A relevant factor to consider was the nature and extent of the amendment sought and the extent to which it changed the Council's case.

50. The Committee considered the amendment application and was satisfied that there would be no unfairness to the Registrant in making the amendment sought, given that as originally worded it was technically incorrect on a strict interpretation. However, the amendment sought did not alter the mischief, nor the seriousness or nature of what was alleged and could be amended without causing injustice. Further, the Committee was of the view that it was in the public interest to make the amendment for the sake of clarity. Accordingly, the Committee determined to grant the application to amend the particular, so that it now read '*On or around 14 November 2021, on a referral, you misdiagnosed Patient A with esotropia*;'.

Mr Corrie's submissions and legal advice

51. In closing submissions, Mr Corrie invited the Committee to accept the evidence of Patient A as truthful, reliable and credible. He gave evidence that was careful, considered and consistent. Furthermore, Patient A's evidence was not really disputed and supported by the wider evidence in the case. Similarly, Witness A gave evidence which was not disputed and was also credible, reliable, clear and consistent, supported by the clinical records.

52. In relation to Patient B's evidence, whilst this was hearsay evidence, Mr Corrie invited the Committee to give it weight, as it was not challenged, supported by the evidence of Witness A and the clinical records.

53. Mr Corrie did not invite the Committee to draw an adverse inference from the fact that the Registrant had not attended the hearing and had not given evidence. He submitted that nonetheless, weight could be given to the admissions that the Registrant had made in his correspondence with the Council and in his representations to the Case Examiners. However, the Committee may wish to bear in mind that the Registrant had not given evidence, so it was untested and had not put forward a positive case.

54. In relation to the expert evidence, Mr Corrie invited the Committee to accept the expert opinion of Dr Kwartz, as she was an experienced clinician and expert witness, who was well placed to comment and gave consistent evidence. It was clear that when she applied the required standard, this was not a gold standard and her rationale was backed up by the relevant guidance.

55. Mr Corrie made submissions on each particular of the Allegation, inviting the Committee to find each particular proved to the required standard i.e. on the balance of probabilities.

56. The Committee accepted the advice of the Legal Adviser that the burden of proving a disputed allegation was on the Council, to the civil standard of the balance of probabilities. In particular, the Legal Adviser gave advice regarding considering each particular of the Allegations separately, that intention can be inferred from the surrounding circumstances and in relation to the Registrant's good character, as he had no previous regulatory findings against him.

Findings in relation to the facts

57. The Committee considered all of the evidence in this case, including the documentary evidence, the oral evidence of the witnesses Patient A and Witness A, the hearsay evidence of Patient B, the documentary evidence, and the expert evidence of Dr Kwartz (both oral and her reports). The Committee also considered the oral and written submissions from Mr Corrie, on behalf of the Council.

58. The Committee considered the denied particulars of the Allegations in turn.

Matter 1, Particular 1

1. On or around 25 August 2020 you failed to send the vision report from the sight test conducted on Patient A on 25 August 2020 to the [redacted] ***Royal Infirmary;***

59. The Committee had regard to the evidence of Patient A that he made clear to the Registrant at the appointment on 25 August 2020, that he required an up to date vision report to be sent to [redacted] Royal Infirmary. He left that appointment under the impression that the Registrant would send such a report. Patient A's evidence was that the sole reason for that appointment was to obtain the vision report and at no stage was Patient A informed by the Registrant that he would not send the report. When Patient A made enquiries in the summer of 2021 with [redacted] Royal Infirmary, about his place on the waiting list, he was informed that they had not received the vision report from the Registrant, following the sight test which took place on 25 August 2020. The Committee considered that the evidence given by Patient A was very clear, consistent and reliable.

60. The Committee noted that there did not appear to be any dispute by the Registrant that such a sight test took place on 25 August 2020 and that he was aware that Patient A wanted an up to date vision report to be sent to the Infirmary. In email correspondence with the Council, dated 3 May 2022, the Registrant stated that he did not send the report as requested by Patient A, as he did not believe that he met the criteria for cataract surgery.

61. The Committee was mindful that where an allegation pleads a failure to act, the Committee needs to first be satisfied that there was a duty upon the Registrant to so act. The Council's expert witness Dr Kwartz set out in her report the standards placed upon Optometrists that are, in her expert opinion, relevant to the sending of the vision report to [redacted] Royal Infirmary. Dr Kwartz states in her report dated 20 January 2023 that:

> "*6.1.2. Performance criterion 1.2.5 of the General Optical Council's Stage 2 Core Competencies for Optometrists (2011) states, "Communicates effectively with any other appropriate person involved in the care of the patient." Performance criterion 2.2.2 of the same document states, "Is able to work within a multi-disciplinary team." In not sending a report to the hospital, I consider that RF (the Registrant) did not fulfil these requirements.*
>
> *6.1.3. Standard 10.1 of the General Optical Council's Standard of Practice for Optometrists and Dispensing Opticians (2016) states, "Work collaboratively with colleagues within the optical professions and other healthcare practitioners in the best interests of your patients, ensuring that your communication is clear and effective." Standard 10.4 states, "Ensure that patient information is shared appropriately with others, and clinical records are accessible to all involved in the patient's care." In not sending the report to [redacted] Royal Infirmary, I consider that RF did not meet these standards*."

62. The Committee accepted the evidence of Dr Kwartz and was satisfied that there was an obligation upon the Registrant in the circumstances to have sent the up to date vision assessment report to the Infirmary, given that one had been requested by Patient A and he was already on the referral pathway for cataract surgery. The Committee considered that the Registrant had a

duty to send the report to the Infirmary, in order to act in Patient A's best interests and to communicate with other professionals regarding his care.

63. Having been satisfied that there was a was a duty upon the Registrant to have sent the vision report from the sight test conducted on Patient A on 25 August 2020, to [redacted] Royal Infirmary, the Committee went on to consider whether he failed to do so. Having regard to the Registrant's account, set out in his correspondence with the Council, in which he accepted not sending it, Patient A's evidence that he was told by the Infirmary that it was not received and there being no evidence of it being sent, the Committee was satisfied that the Registrant failed to send the vision report to the Infirmary.

64. Considering all of the above matters, the Committee found particular 1 of the Allegation proved.

Matter 1, Particular 2

2. On or around 14 November 2021, on a referral, you misdiagnosed Patient A with esotropia;

65. The Committee had regard to the Registrant's referral to Dr B, dated 14 November 2021, which was sent by email. In that referral, the Registrant wrote,

> "*[Patient A] has been kind enough to provide me with your e-mail address to expedite the referral process for him. He has recently developed a moderate left lateral esoptropia [sic], which has been partially masked by the presence of ptosis.*
>
> *I should be most grateful if you could refer him to the Eye Department at* [redacted] *as a matter of some urgency, as the severity of this condition precludes any Cataract Extraction, a full investigation of the oculomotor imbalance needing to be undertaken*."

66. The Committee noted that the Registrant did not appear to dispute that he had sent this referral, which referred to Patient A having esotropia (an inward turning deviation). However, in the handwritten clinical note from the aborted cataract surgery on 11 November 2021, the notes were interpreted by Dr Kwartz to read that Patient A had exotropia (an outward turning deviation). Further, Patient A had described the condition as consistently being an outward turning squint and subsequent hospital correspondence also confirmed an outward turning deviation. The Committee was therefore satisfied that the condition Patient A had was exotropia, rather than esotropia and that the Registrant had made an error in that respect.

67. The Committee went on to consider whether in sending the referral dated 14 November 2021, it was the Registrant that was making a (mis)diagnosis, or rather he was, albeit incorrectly, communicating the diagnosis that had

previously been made by the surgeon Mr H, who had cancelled the surgery on 11 November 2021.

68. The Committee considered the witness statement of Patient A as to his attendance at [redacted] for cataract surgery on 11 November 2021. Witness A described events at that appointment and made no mention of the Registrant being present at the examination on that date. The Committee was of the view that there was no evidence that the Registrant was present during Mr H's assessment of Patient A.

69. Patient A's evidence was that it was the surgeon, Mr H, who cancelled the surgery because he detected the condition. The notes dated 11 November 2021, which Dr Kwartz had assumed were recorded by the surgeon Mr H, rather than the Registrant, were in the Committee's view brief, not very clear and difficult to read.

70. The Committee was of the view that on the evidence before it, there was insufficient evidence to be satisfied on the balance of probabilities that the Registrant made the diagnosis of esotropia. The Committee considered that it was more likely that the Registrant had sent the referral email several days after the surgeon Mr H had made a diagnosis, and based the referral email upon his interpretation of Mr H's handwritten notes, having misread exotropia as esotropia.

71. The Committee was of the view that in these circumstances, the Registrant making an error when interpreting Mr H's handwriting would not amount to the Registrant making a diagnosis of esotropia, as the Committee was not persuaded that the Registrant made any diagnostic analysis of his own in respect of Patient A's conditions.

72. In the circumstances, the Committee was not satisfied that particular 2 of the Allegation was proved.

Matter 1, Particular 3

3. You failed to make any, or any adequate, clinical record of:
a. the sight test conducted on Patient A on or around 25 August 2020. and/or
b. the sight test conducted on Patient A on or around 9 July 2021; and/or
c. the pre-cataract surgery assessment you carried out on Patient A on 10 August 2021.

73. The Committee firstly considered whether there was a duty upon the Registrant to make adequate clinical records in respect of these appointments with Patient A and was so satisfied. The Committee accepted the evidence of Dr Kwartz, which was that:

"*keeping clinical records is a fundamental component of patient management and not doing do can potentially significantly compromise a patient's outcomes*."

74. Furthermore, Dr Kwartz had set out in her addendum report, dated 18 September 2023, in relation to the pre-cataract surgery assessment, what in her opinion ought to have been recorded in a clinical record by a reasonably competent Optometrist carrying out such assessments. The Committee accepted Dr Kwartz's evidence in that regard.

75. The Committee noted that it was taken through the limited records that had been provided by the Registrant which related to these appointments, and these had been described by Dr Kwartz as being more akin to prescription statements, given to patients after the appointment with their prescription details on, than patient records. The Committee noted that the Registrant, in correspondence with the Council, had been asked to confirm that he had provided all of the patient records in respect of Patient A and he had confirmed that he had done so.

76. The Committee noted that the Registrant's record-keeping was not reflective of a contemporaneous clinical record nor was it clear and there was an issue with the dates, which made identification of what occurred on what date, difficult to ascertain. The Registrant had explained in correspondence with the Council, that a software update had erased some of the dates in the patient records, which had then been annotated by hand. The Committee noted that the Registrant's explanation related to the dates and he did not appear to be maintaining that the patient records themselves had been deleted due to this issue.

77. The Committee noted that this particular of the Allegation refers to whether '*any, or any adequate, clinical record*' was made. Dr Kwartz was of the view that there were no documents provided by the Registrant which corresponded to a clinical record from a sight test or a pre-cataract surgery assessment. The Committee considered each sub-particular separately and was of the view the limited records that were provided did contain some limited clinical information, albeit not to the extent that would be expected. The Committee was of the view that in relation to all three appointments with Patient A, the Registrant had made a clinical record, in that there was some record of the appointment containing limited clinical information. However, the Committee considered that what was recorded was inadequate considering what a reasonably competent Optometrist was expected to record following a sight test or pre-cataract surgery assessment.

78. Accordingly, the Committee found this particular proved on the basis that the Registrant had not made any adequate clinical records in respect of all three appointments.

Matter 2, Particular 1

1) On or around 8 March 2022 you failed to record details about Patient B's symptoms in relation to:

a. History and/or

b. Character of the symptoms and/or

c. Duration of the symptoms and/or

d. Onset of the symptoms.

79. The Committee had regard to the expert evidence in relation to Patient B, which was set out in Dr Kwartz's report, dated 3 November 2022, and addendum report, dated 18 September 2023. In relation to the duty to record details regarding Patient B's symptoms, Dr Kwartz stated that:

> "*6.1.2. The only information regarding Patient B's symptoms are a brief handwritten note on one of the pages of OCT results. [see C/430] The symptom which was documented was that there was total loss of vision in the right eye. I do not consider that sufficient information regarding this symptom was recorded. A reasonably competent optometrist would ask further questions regarding the onset of the symptom and establish characteristics of its onset and duration eg gradual or sudden, constant or intermittent and whether there were any associated complaints eg distortion, altered colour perception, flashes of light and/or floaters, a curtain over the vision and if one part of the visual field appeared to be more significantly affected than elsewhere. In his email of 23 May 2022, RF avers that the duration of the symptom was 3 days, but this information was not documented contemporaneously.*
>
> *6.1.3. Paragraph A51 of the prevailing College of Optometrists' Guidance for Professional Practice (2021) states, "You must conduct an adequate assessment for the purposes of the optical consultation. This should normally include: ... history including description of onset, character and duration of signs and symptoms." Whilst I acknowledge this guidance relates to a routine eye examination and Patient B had attended for an examination relating to specific symptoms, rather than to a routine check, I consider the standard of history-taking that is required should be the same irrespective of the reason for the examination - in fact, a detailed history is more apposite in a patient who presents with significant visual loss*."

80. The Committee accepted the evidence of Dr Kwartz set out above, as to the requirements placed upon a reasonably competent Optometrist to record details of a patient's symptoms, as found in the College of Optometrists' Guidance. Accordingly, the Committee was satisfied that there was a duty upon the Registrant to record details of Patient B's symptoms, in relation to their history, character, duration and onset.

81. The Committee went on to consider the evidence in respect of whether the Registrant had in fact failed to record such matters regarding Patient B's symptoms and considered sub-particulars a) - d) separately.

82. The Committee noted that the Registrant had made admissions in respect of his record-keeping in his representatives' (the AOP) representations to the Case Examiners, dated 1 February 2023, made in relation to Patient B. It was stated in those representations that the Registrant had taken details from Patient B in a phone call on 7 March 2022, the day before the appointment, but they were not recorded by him. The Committee considered that these admissions could be relied upon, given that he was represented at the time and subject to regulatory proceedings. The Committee was of the view that these admissions would not be made lightly and there was no indication since these admissions were made that the Registrant had sought to change his position.

83. The Committee noted that the Allegation was not whether adequate details had been recorded or not by the Registrant, rather whether details had been recorded. The Committee considered that the only evidence of a record that the Registrant had made of the appointment with Patient B on 8 March 2023, was the handwritten noted of that date, which stated, "*8.3.22 – Total loss of vision RE due to PED?*". The Committee was of the view that this could be considered to describe the character of the symptoms, albeit in a minimal level of detail, in that it records a total loss of vision in the right eye. However, this note did not detail the history, duration or onset of the symptoms and there was no evidence in the records provided by the Registrant that such matters had been recorded.

84. Accordingly, the Committee determined that particulars 1 a), c) and d) were found proved and particular 1 b) was on the balance of probabilities, found not proved.

Matter 2, Particular 2

2) On or around 8 March 2022 you failed to conduct an adequate sight test on Patient B in that you:

a. Failed to undertake Patient B's levels of acuity, and/or

b. Failed to check for relative afferent pupil defects, and/or

c. Failed to conduct a pinhole examination, and/or

d. Failed to detect signs of Patient B's swollen right optic nerve.

85. The Committee noted that the Council had brought particulars 2 and 3 in the alternative and firstly considered particular 2, whether the Registrant had carried out the tests listed at a) – d).

86. The Committee was satisfied that there was a duty upon the Registrant to carry out an adequate sight test on Patient B, particularly given the

seriousness of her presentation and symptoms, which involved an almost total loss of sight in her right eye.

87. The Committee noted the Registrant's account in the AOP's representations to the Case Examiners, dated 1 February 2023, in which he stated that he carried out a check of Patient B's level of acuity, which was "*fingers only recognition.*" The Committee noted that this information was not recorded in any clinical records relating to Patient B, and was only documented in the representations. Further, this information provided regarding Patient B's acuity was only in relation to the symptomatic eye, not both eyes.

88. The Registrant accepted in this account that he did not check for a relative afferent pupil defect, nor did he conduct a pinhole examination, or an examination of the optic disc. Furthermore, there is no evidence in any of the patient records provided that any of these tests were carried out. Whilst the Registrant did carry out an OCT scan, it was the view of the Committee that this in itself did not amount to an adequate sight test given the presentation of Patient B and the serious symptoms that she reported.

89. The Committee considered that it could rely upon the admissions made by the Registrant, as set out above. In addition, the Registrant had confirmed in an email to the Council dated 23 May 2022, that he did not complete a fuller eye examination (than the OCT scan undertaken), as he felt that would not have been appropriate.

90. The Committee was satisfied that based upon the Registrant's admissions and the lack of records to establish that any such checks were undertaken, sub-particulars b), c) and d) were found proved.

91. In relation to sub-particular a), which the Registrant did not admit, as he maintained that he checked Patient B's levels of acuity, the Committee considered that there was no evidence that the Registrant checked the acuity in both eyes, (even if he might have done so in the symptomatic eye), which a complete test would have required. Furthermore, there is no contemporaneous entry in the patient records provided by the Registrant, which he confirmed was the entirety of the records, to support that Patient B's acuity was checked by the Registrant. On the balance of probabilities, the Committee was satisfied that sub-particular a) was also proved.

Matter 2, Particular 3

3) In the alternative to 2) above on or around 8 March 2022 you failed to make an adequate record of the sight test conducted on Patient B in that you:

a. Failed to record Patient B's levels of acuity, and/or

b. Failed to record relative afferent pupil defects, and/or

c. Failed to record a pinhole examination, and/or

d. Failed to record signs of Patient A's (SIC – Patient B) swollen right optic nerve.

92. The Committee noted that this particular of the Allegation was in the alternative to Matter 2, particular 2. Given that the whole of particular 2 was found proved, the Committee did not go on to consider the alternative particular 3, of failing to record such matters.

Matter 2, Particular 4

4) You failed to urgently refer Patient B to a hospital eye service for further investigation of their symptoms when it was indicated to do so.

93. The Committee was satisfied on the evidence before it, that given the significance of Patient B's symptoms and the potentially serious implications, there was an obligation upon the Registrant to urgently refer Patient B to a hospital eye service for further investigation. The Committee had regard to the expert evidence of Dr Kwartz, and also the evidence of Witness A, who had examined Patient B shortly after the Registrant had and who had correctly observed Patient B's significantly swollen optic disc and made a same day referral.

94. Dr Kwartz opined in her addendum report dated 18 September 2023, in relation to the presentation of Patient B, that:

> "*A swollen disc is a 'red flag' clinical sign until proven otherwise, as it can signify very serious underlying pathologies eg a space-occupying lesion or giant cell arteritis. A swollen disc can be associated with conditions that are both sight- and life-threatening."*

95. Further, in her report dated 3 November 2022, Dr Kwartz states:

> *"6.7.3. In their guidance on referral urgency, the College of Optometrists states that papilloedema should be referred within 24 hours. Whilst I appreciate that Patient B did not have papilloedema which is where both the right and left optic discs are swollen, I consider that the guidance is appropriate even for a unilateral swollen disc. 6.7.4. As a minimum, the College of Optometrists states that an urgent or priority referral should be made by telephoning the eye department for triage in cases of suspected cancers, a suspected compressive lesion or a new pupillary defect. Patient B's presentation definitely fell into these 3 categories."*

96. Whilst the Registrant did recognise that Patient B ought to be seen by a specialist, he made a follow-up appointment with an Ophthalmologist at his practice, for four days later with no alternative plan offered. Given the seriousness of Patient B's presenting symptoms, the guidance from the College of Optometrists, and Dr Kwartz's opinion, the Committee considered that this management was inappropriate, as an urgent, same day referral to ascertain the underlying cause was clearly indicated. Furthermore, the Committee accepted the evidence of Witness A, who also examined Patient B on the same day of the Registrant and who stated that Patient B's swollen disc was not subtle but "*impossible to miss*".

97. In addition, the Committee noted that in the AOP's representations on behalf of the Registrant to the Case Examiners, it was stated that the Registrant should have either:

> *"• Recognised the swollen optic disc and referred the patient as an emergency; or*
> *• Recognised that PED was not consistent with the presenting symptoms ('total loss of vision in one eye') and arranged further urgent investigation."*

98. Accordingly, the Committee determined that Matter 2, Particular 4 was found proved.

Matter 2, Particular 5

5) You misdiagnosed Patient B with suspected pigment epithelial detachment.

99. The Committee noted that the Registrant had suspected that Patient B was suffering from a pigment epithelial detachment ('PED'), which was what he had written in his handwritten note dated 8 March 2022, when he annotated the OCT scan taken on that date. Further, the Registrant confirmed that this was his suspicion in the correspondence with the Council.

100. The Committee had regard to the evidence of Dr Kwartz and Witness A, who both gave evidence that the presentation of Patient B did not align with a diagnosis of PED and further, that the swollen optic disc was obvious. The Committee was satisfied on the basis of the evidence before it that PED was a misdiagnosis.

101. The Committee considered the submission made on behalf of the Registrant in the AOP's representations to the Case Examiners, which was that there was no duty upon an Optometrist under the Opticians Act 1989 to make a diagnosis of eye conditions, as that was the responsibility of medical practitioners. Rather, it was submitted on behalf of the Registrant, the role of an Optometrist is to detect signs of 'injury, disease or abnormality in the eye'.

102. In considering this issue, the Committee was assisted by and accepted the evidence of Dr Kwartz, which was as follows:

> *"3.3.1. PEDs can occur in several conditions, but most commonly in patients with age-related macular degeneration. A PED can have different underlying causes eg serous (due to fluid accumulation), drusenoid (due to drusen) or fibrovascular (where a neovascular membrane has developed in 'wet' age- related macular degeneration). There is a responsibility of an optometrist to identify a PED and consider its type. Within the context of Patient B's examination, I assume that Mr Fyfe thought the diagnosis to be*

serious PED. Whilst a serious PED in its own right may not be considered a sight-threatening entity, it is a sign of dysfunction of the outer retinal layers and may be a harbinger of subsequent disease.

3.3.2. There is, therefore, a responsibility for an optometrist to diagnose a PED."

103. Where there was a difference in opinion between the Registrant and Dr Kwartz on this issue, the Committee preferred the evidence of Dr Kwartz, as the expert witness.

104. The Committee recognised the duties placed upon Optometrists under the Opticians Act 1989 to identify abnormalities. It was of the view that the Registrant, as an Optometrist, did have a duty to identify any abnormality including making a differential diagnosis of the potential causes where appropriate in order to make an appropriate referral. In relation to Patient B, the Registrant had failed to detect the swelling of the optic nerve, which was an obvious abnormality of the eye and went on to propose a different diagnosis and management that was incorrect.

105. Furthermore, the Committee noted that this particular of the Allegation did not plead that the Registrant failed to diagnose, in which case the question of whether the Registrant was under a duty to diagnose or not would specifically arise. Rather it was a factual issue of whether the Registrant misdiagnosed Patient B with suspected PED.

106. The Committee was satisfied on the basis of Dr Kwartz's evidence in particular, as well as Witness's evidence regarding the clear presentation of the clinical signs, that the Registrant misdiagnosed Patient B with suspected PED and accordingly, this particular is found proved.

Misconduct

107. The Committee proceeded to consider whether the facts found proved amounted to misconduct which was serious.

108. The Committee heard submissions from Mr Corrie, on behalf of the Council. No further material was put before the Committee at this stage.

109. Mr Corrie reminded the Committee that misconduct was not a matter of proof, rather it was for the Committee's own independent judgement. He invited the Committee to find that on the basis of the facts found proved, the Registrant's failings were sufficiently serious to amount to misconduct.

110. The Council relied upon the evidence of Dr Kwartz on the issue of misconduct and in her opinion, all of the conduct that had been found proved fell not just below, but far below, the standards required of a reasonably competent Optometrist. Mr Corrie submitted that as Dr Kwartz was an

experienced clinician and expert, who applied the correct test, this was a strong indicator that the Registrant's failings amounted to misconduct.

111. In relation to Patient A (matter 1, particular 1), the Registrant failed to ensure that the up to date visual assessment report was sent to the Infirmary, leading to a delay in Patient A receiving treatment for his cataracts. In addition, this caused a breakdown in the relationship between the Registrant and Patient A, as well as causing Patient A upset. Dr Kwartz's view was that there was a duty upon the Registrant to send the report and by not doing so, this fell far below the standards expected.

112. Mr Corrie highlighted Dr Kwartz's evidence on the record-keeping in respect of Patient A (matter 1, particular 3), which the Committee had found was inadequate. Dr Kwartz was unable to tell what had taken place in these appointments and this defeated the purpose of a clinical record, if a subsequent practitioner – for example a locum - was unable to establish what had happened. Mr Corrie submitted that this was serious, as the view of Dr Kwartz was that this could put patients at significant risk of harm.

113. Mr Corrie reminded the Committee of Dr Kwartz's evidence in relation to Patient B (matter 2, particular 1), which was that the Registrant's failures to record details regarding Patient B's symptoms fell far below the standards expected. Mr Corrie submitted that this was a serious and significant failure.

114. Furthermore, in relation to the Registrant's inadequate examination of Patient B (matter 2, particular 2), this was submitted to be a serious failure, as the Registrant failed to detect that the right optic nerve was significantly swollen. The Registrant failed to urgently refer Patient B for an appointment within 24 hours (matter 2, particular 4), as was indicated by her clinical symptoms, instead making her a follow up appointment with a specialist four days later. Mr Corrie submitted that it was fortunate for Patient B that she was prompted by a pharmacist to seek a further opinion and was seen by Witness A later that day who did correctly urgently refer her. The fact that another practitioner made an urgent referral did not detract from the Registrant's serious failure to do so.

115. In relation to misdiagnosing Patient B with PED, Mr Corrie submitted that this was a serious failure, as it was a mischaracterisation of something that it was not. Further, Dr Kwartz's view was that this fell far below the required standard of a reasonably competent Optometrist.

116. Mr Corrie referred the Committee to the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*", effective from April 2016 ('the Standards'). Mr Corrie invited the Committee to find that the Registrant has departed from the following standards by virtue of his conduct:

- *Standard 7: Conduct appropriate assessments, examinations, treatments and referrals;*
- *Standard 8: Maintain adequate patient records.*

117. Mr Corrie invited the Committee to find that there had been serious breaches of the standards, which amounted to misconduct.

118. The Committee heard and accepted the advice of the Legal Adviser, who referred the Committee to the section on misconduct in the Guidance. In particular, the Legal Adviser referred to the case of *Roylance v General Medical Council (no2)* [2000] 1 AC 311, regarding the two principal kinds of misconduct, either conduct linked to professional practice or conduct that otherwise brings the profession into disrepute. The Committee was reminded that misconduct was a matter for its own independent judgement and no burden or standard of proof applied at this stage. Further, that the Committee needed to consider whether the conduct was sufficiently serious to amount to professional misconduct.

The Committee's findings on misconduct

119. The Committee considered the "*Council's Standards of Practice for Optometrists and Dispensing Opticians*" and the standards which it had been referred to by the Council, namely 7 (conduct appropriate assessments and referrals) and 8 (maintain adequate records), which the Committee was satisfied both applied in this case. In addition, the Committee also considered that the following standards applied:

- *1.2 Listen to patients and take account of their views, preferences and concerns, responding honestly and appropriately to their questions;*
- *7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors;*
- *8.1 Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care;*
- *10.1 Work collaboratively with colleagues within the optical professions and other healthcare practitioners in the best interests of your patients, ensuring that your communication is clear and effective;*
- *10.4 Ensure that patient information is shared appropriately with others, and clinical records are accessible to all involved in the patient's care;*
- *17.1 Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession;*
- *17.3 Be aware of and comply with the law and regulations that affect your practice, and all the requirements of the General Optical Council.*

120. The Committee was satisfied that in respect of all of the above standards, the conduct of the Registrant, as found proved, had fallen below the expected standards of what was proper in the circumstances.

121. The Committee was mindful that not every falling short of the standards was sufficient to amount to misconduct, as it must be serious. The Committee went on to consider whether the Registrant's failures were serious in relation to each particular in the Allegation that was found proved.

122. The Committee had regard to the expert evidence in the case of Dr Kwartz, who in both her oral and written evidence had given her expert opinion on whether the failings fell below or far below the standards expected of a reasonably competent Optometrist. The Committee noted that Dr Kwartz was of the opinion that in respect of all of the failings in this case, both the record-keeping and the assessment and management of patients, the conduct fell far below what was expected in the circumstances.

123. In relation to matter 1, particular 1 and the Registrant's failure to send Patient A's vision report to the Infirmary, the Committee considered that this was serious, as it was not simply an administrative error, but the Registrant's decision not to send the report. This was despite Patient A's clear request that the report be sent and the Registrant having left Patient A with the impression that he would do so. The Registrant's conduct in not sending the report resulted in delay of over one year for Patient A's cataract treatment.

124. Further, in Dr Kwartz's opinion the Registrant's conduct in respect of Patient A fell far below expected standards due to his failure to send the up to date vision report to the hospital, as requested by Patient A. Dr Kwartz stated in her report that:

> *"6.1.1. I consider that on this date, RF fell far below the standard of a reasonably competent optometrist in not sending a report to [redacted] Royal Infirmary. My rationale is that an optometrist should always act in their patient's best interests and, in this instance, sharing clinical information with the hospital was definitely appropriate. My rationale for choosing far below rather than below is because sending the clinical data was a fundamental component in Patient A's care and withholding the information had a potentially negative impact on Patient A's onward clinical management.*
>
> *6.1.2. Performance criterion 1.2.5 of the General Optical Council's Stage 2 Core Competencies for Optometrists (2011) states, "Communicates effectively with any other appropriate person involved in the care of the patient." Performance criterion 2.2.2 of the same document states, "Is able to work within a multi-disciplinary team." In not sending a report to the hospital, I consider that RF did not fulfil these requirements.*
>
> *6.1.3. Standard 10.1 of the General Optical Council's Standard of Practice for Optometrists and Dispensing Opticians (2016) states, "Work collaboratively with colleagues within the optical professions and other healthcare practitioners in the best interests of your patients, ensuring that your communication is clear and effective." Standard 10.4 states, "Ensure that patient information is shared appropriately with others, and clinical records are accessible to all involved in the patient's care." In not sending the report to [redacted] Royal Infirmary, I consider that RF did not meet these standards."*

125. In relation to matter 1, particular 3, which related to the Registrant's inadequate clinical records, the Committee was of the view that this was serious misconduct. The Committee noted the example given by Dr Kwartz

that she assesses the adequacy of records by considering whether a locum would understand what had happened at previous appointments. In this case, although some clinical data had been recorded, the record-keeping of the Registrant was so poor that Dr Kwartz was unable to ascertain what had happened at these appointments. It was the view of Dr Kwartz that this conduct fell far below the standards to be expected of a reasonably competent Optometrist and her rationale was that, *"keeping clinical records is a fundamental component of patient management and not doing so can potentially significantly compromise a patient's outcomes."* Further, Dr Kwartz stated that:

> *"6.10.3.I consider that Robert Fyfe's optometric records for the 3 examinations to fall far below the expected standard as there is no basis on which ongoing care can be provided, which could potentially put the patient at significant risk of harm."*

126. In relation to matter 2, particular 1, concerning Patient B, the Committee considered that the Registrant's failure to record details regarding Patient B's symptoms was serious, particularly given that Patient B had attended with very significant clinical complaint, of complete loss of vision in one eye. Whilst the Committee had found that the Registrant had recorded some characteristics of the symptoms, this was only minimal details of the symptoms. Given the serious sudden visual loss of Patient B the Registrant's record-keeping in respect of Patient B was a significant departure from what would be expected of a reasonably competent Optometrist.

127. In addition, the Committee accepted the evidence of Dr Kwartz who was of the opinion that the Registrant's record keeping in respect of Patient B fell seriously below the standards expected due to the number of omissions from the record, which was missing information fundamental to patient care. Dr Kwartz stated that:

> *"6.1.5. For all the omissions detailed in this section, I consider that RF's standard fell far below that of a reasonably competent optometrist. My reasoning is that taking a full history and performing a complete clinical examination are profoundly important in a patient who presents with visual loss in order to provide a basis for their ongoing clinical investigations and care."*

128. The Committee considered that in relation to matter 2, particular 2, and its finding that the Registrant failed to conduct an adequate sight test on Patient B, this was serious misconduct as the Registrant failed to carry out fundamental tests that would be expected to be carried out in a patient that presented with almost total sight loss. In reaching this view, the Committee again accepted the evidence of Dr Kwartz at paragraph 6.1.5 of the report referred to above.

129. In relation to matter 2, particular 4, the Committee accepted the evidence of Dr Kwartz that, in her expert opinion, the Registrant's conduct in relation to

Patient B, by not recognising the obvious clinical presentation of Patient B and by failing to make an urgent referral for further investigation of her symptoms, this fell far below the standards expected of a reasonably competent Optometrist. Dr Kwartz stated that the referral strategy of the Registrant, in arranging an in-house appointment four days later fell far below that of a reasonably competent Optometrist, in that "*it did not allow for emergency assessment of Patient B's potentially sight- and life-threatening pathology".*

130. The Committee considered that in relation to matter 2, particular 5, the Registrant's misdiagnosis of Patient B was serious, as it ought to have been obvious to the Registrant from the clinical signs what the correct issue was. The Committee noted the evidence that Patient B's presentation was not subtle or borderline and it was subsequently immediately obvious to Witness A. The Committee accepted the evidence of Dr Kwartz that this failing was seriously below the standards expected and carried a risk to sight and even a risk to life. Addressing the Registrant's misdiagnosis of Patient B with PED, Dr Kwartz stated that:

"3.2.3. However, irrespective of whether any subsequent images show a PED, as the optic disc swelling on 8 March 2022 was so frank, I consider the misdiagnosis fell far below the standard of a reasonably competent optometrist, due to the potential implications explained in 3.1.1"

131. In relation to all of the particulars that were found proved, in respect of both Patient A and Patient B, the Committee was satisfied that the Registrant's conduct fell sufficiently far below the standards expected of a reasonably competent Optometrist to amount individually to misconduct, which was serious, in each instance.

132. Accordingly, the Committee found that the facts found proved do amount to misconduct which is serious.

Findings regarding impairment

133. The Committee went on to consider whether the Registrant's fitness to practise is currently impaired by virtue of his misconduct.

134. The Committee heard submissions from Mr Corrie on behalf of the Council, who submitted that the Registrant's fitness to practise is currently impaired on public protection grounds and that a finding of impairment was necessary in the wider public interest.

135. Mr Corrie submitted that the Registrant's conduct was possibly remediable, as it was of a clinical nature. However, this was subject to the engagement of the Registrant and his demonstration that the shortfalls in his practice had been satisfactorily addressed. In this case, the shortfalls had not been

remedied by the Registrant, as he had not demonstrated that any steps to remediate had been taken.

136. Mr Corrie informed the Committee that the website of [redacted] now showed that the practice was closed due to the Registrant's retirement. Mr Corrie referred the Committee to the case of *GOC v Clarke* [2018] EWCA 1463, in which the Court of Appeal held that the issue of retirement was not relevant to fitness to practise. Mr Corrie submitted that the Committee ought to consider the case on the basis of whether the risks had been remedied, regardless of whether the Registrant may have retired or not.

137. Mr Corrie submitted that the Registrant had not engaged with these proceedings and there had been no evidence submitted by him regarding matters such as CPD, insight, reflection, remorse, or other remediation. In the circumstances, there was no basis to conclude that there had been remediation of his failures and as a result there would continue to be a risk of harm to the public. Accordingly, Mr Corrie invited the Committee to find that the Registrant's fitness to practise was currently impaired on public protection grounds.

138. Mr Corrie referred to the public interest and stated that the need to uphold professional standards and maintain public confidence in the profession would be undermined if no finding of impairment was made. He submitted that as this case concerned clinical matters, if the Registrant had engaged and sufficiently addressed the concerns and remediated, then there may have been an argument that a finding of impairment on public interest grounds was not necessary. However, that is not the case, as the Registrant has not taken any steps to remediate nor engaged with the process. Therefore, the wider public interest requires a finding of current impairment in this case to declare and uphold standards and maintain public confidence in the profession.

139. The Committee accepted the advice of the Legal Adviser who advised the Committee that the question of impairment was a matter for its independent judgement taking into account all of the evidence it has seen and heard so far. She reminded the Committee that a finding of impairment does not automatically follow a finding of misconduct and outlined the relevant principles set out in the cases of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and *Cohen v GMC* [2008] EWHC 581 (Admin). The Legal Adviser confirmed that she agreed with Mr Corrie regarding the correct approach to the issue of the Registrant's retirement, following the case of *GOC v Clarke* [2018] EWCA 1463.

140. The Committee considered whether the Registrant's conduct was capable of being remediated, whether it had been remediated and whether there is a risk of repetition of the conduct in future.

141. The Committee was of the view that the nature of the conduct in this case, namely clinical failings, was capable of being remediated with insight and remediation. However, the Committee considered that there was no substantial insight demonstrated by the Registrant in this case. Further, it

was concerned that he had not provided evidence of undertaking reflection, or taking any steps to remediate his behaviour. Although the Registrant had accepted some of the failures in his correspondence with the Council and the Case Examiners, the Committee noted that the Registrant had not apologised, nor shown that he was remorseful for his conduct.

142. The Committee noted that in the AOP's representations to the Case Examiners, dated 1 February 2023, it was stated that the Registrant had "*undertaken significant training and education to ensure that there is no risk of repetition. He has demonstrated insight and has incorporated changes into his current practice."* However, no evidence of this was before the Committee, such as details of the shadowing of consultants, or certificates from the CPD courses attended, nor is there any evidence to demonstrate what the Registrant has learned from such courses. The Committee considered that it had not received any material indication that the Registrant fully understood the seriousness of the matters which have been found proved and what he would need to do to address the concerns raised in this case.

143. The Committee concluded that the Registrant's insight into his conduct was highly limited, and he still has significant work to do in this respect in order for the Committee to be reassured that he has remediated his misconduct. However, there was no indication that the Registrant was willing to complete the work required, as he has disengaged from these proceedings.

144. The Committee was of the view that the Registrant's conduct had put patients at risk of harm in the past and the Committee was concerned that without further reflection, insight and remediation, he would do so in future. Given the lack of evidence of insight and remediation by the Registrant to address the failings, the Committee was of the view that there was a high risk of repetition.

145. The Committee accepted the submission of Mr Corrie, and the legal advice received, regarding the Registrant's retirement from practice and the case of *GOC v Clarke* [2018] EWCA 1463. Accordingly, the Committee assessed the position regarding impairment, and the risk of repetition, on the basis of whether the Registrant's fitness to practise is currently impaired, should he return to practice, regardless of any indication, via his website, that he is retiring permanently.

146. Considering all of the above, the Committee was satisfied that the Registrant's fitness to practise is currently impaired on public protection grounds.

147. The Committee next turned to consider the public interest and had regard to the case of *CHRE v (1) NMC and (2) Grant* [2011] EWHC 927 (admin) and the test that was formulated by Dame Janet Smith in the report to the Fifth Shipman Inquiry, which is considered to be an appropriate approach for panels considering impairment (framed in respect of doctors but applicable to Optometrists):

"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. has in the past acted dishonestly and/or is liable to act dishonestly in the future."

148. The Committee was of the view that limbs (a)-(c) of the test in *Grant* are engaged in this case, both in respect of the Registrant's past conduct and also in relation to the Registrant being '*liable in the future'*, to put patients at unwarranted risk of harm, bring the profession into disrepute, and breach a fundamental tenet of the profession.

149. Further, given the serious nature of the conduct, which concerned several fundamental failings, resulting in potential harm to patients, the Committee concluded that the public would be extremely concerned if no finding of impairment was made, and this would undermine the public interest. The Committee determined that it was also necessary to make a finding of impairment in this case in order to maintain confidence in the profession, and the Regulator and in order to uphold proper professional standards.

150. Accordingly, the Committee found that the fitness of the Registrant Mr Robert Fyfe to practise as an Optometrist is currently impaired.

Sanction

151. The Committee went on to consider what would be the appropriate and proportionate sanction, if any, to impose in this case. The Committee received no new material at this stage, including from the Registrant who continued not to engage in the proceedings.

152. The Committee heard submissions from Mr Corrie on behalf of the Council. Mr Corrie highlighted to the Committee the principles that it ought to apply in determining the appropriate sanction, if any, in this case. These included to bear in mind the stated aim of sanctions, which is to protect the public and the public interest factors of maintaining public confidence in the profession and upholding proper professional standards and conduct.

153. Mr Corrie reminded the Committee to apply the principle of proportionality, balancing the Registrant's interests against the wider public interest and that

the sanction imposed must be the least onerous to protect the public and meet the public interest.

154. Mr Corrie proposed that mitigating factors in this case could be the Registrant's long career, with hitherto no fitness to practise history and the fact that some admissions were made by the Registrant in his correspondence with the Case Examiners.

155. In relation to aggravating factors, Mr Corrie submitted that it was an aggravating feature of the case that the misconduct was linked to two separate patients, that in relation to Patient A there was a delay to their cataract treatment and in relation to Patient B, the Registrant failed to see an obvious sign which might indicate a life-threatening condition. Furthermore, he invited the Committee to consider as an aggravating factor, that the Registrant had not shown meaningful insight, or any remorse and had not apologised.

156. Mr Corrie submitted that the Council's position was that suspension was the least onerous sanction that would be appropriate and proportionate in this case. He submitted that taking no further action would be clearly inappropriate and would not protect the public and neither would the imposition of conditions. Mr Corrie submitted that where there were discrete clinical issues then often conditions could be appropriate. However, this was based upon a Registrant engaging and being willing to abide by the conditions imposed by the Committee. Here, the Committee could not be satisfied that the Registrant would abide by any conditions and if anything the opposite is true, in that compliance would be unlikely.

157. Mr Corrie invited the Committee to consider the sanction of suspension as the appropriate and proportionate sanction to impose in this case, as this would prevent the Registrant from practising and would protect the public. Mr Corrie highlighted that the issue may be whether a suspension would meet the wider public interest and submitted that if the nature of the misconduct was considered, whilst serious, it might not be such that it would cross the threshold for erasure.

158. Mr Corrie took the Committee through the factors that indicate that erasure may be appropriate, as set out in paragraph 21.35 of the Guidance and submitted that b) creating or contributing to a risk of harm to individuals and h) persistent lack of insight, might apply. Mr Corrie explained that whilst the Council considered that suspension may be appropriate, he was highlighting the sections of the Guidance on erasure in case the Committee considered that it was the appropriate sanction at this stage, given the likely continued non-engagement of the Registrant.

159. Mr Corrie, upon being asked questions by the Committee, made submissions on a financial penalty and confirmed that he was not instructed to seek such a sanction and that financial penalties may be more appropriate in cases where the misconduct is financially motivated or there had been financial gain, which is not the case here.

160. Further, Mr Corrie confirmed that paragraph 21.35 a) of the Guidance, a further factor indicating erasure, also arguably applied, namely a serious departure from relevant professional standards. Mr Corrie stated that if the Committee was minded to suspend the Registrant, the Council would invite the Committee to direct that a Review hearing take place.

161. The Committee accepted the advice of the Legal Adviser, which was for the Committee to take into account the factors on sanction as set out in the Guidance; to assess the seriousness of the misconduct; consider any aggravating and mitigating factors; and to consider the range of available sanctions in ascending order of seriousness. Further, the Committee is required to act proportionately by weighing the interests of the Registrant against the public interest.

The Committee's findings on sanction

162. The Committee considered the aggravating and mitigating factors that were present in this case. In the Committee's view, the aggravating factors are as follows:

i) The breadth of misconduct, in that there was a range of serious clinical deficiencies, concerning significant clinical and record-keeping failings in respect of two patients, over a period of approximately 18 months;

ii) In respect of Patient A, there had been a delay in treatment for cataract removal surgery of over a year;

iii) In respect of Patient B, the misconduct was aggravated by the seriousness of her symptoms and the obviousness of the clinical sign missed;

iv) No meaningful evidence of insight, remediation, apology or remorse.

163. The Committee considered the following to be mitigating factors:

i) The Registrant has had a very long career, of over three decades, with no prior fitness to practise history;

ii) The Registrant made some admissions in his early correspondence with the Case Examiners.

164. The Committee acknowledged that the Registrant had initially engaged in the regulatory process up until February 2023, however this factor was not given any material weight by the Committee given that the Registrant's engagement was subsequently curtailed.

165. The Committee considered the sanctions available to it from the least restrictive to the most restrictive, starting with no further action.

166. The Committee considered taking no further action as set out in paragraphs 21.3 to 21.8 of the Guidance. It was of the view that there were no exceptional circumstances to justify taking no action in this case. It further

considered that taking no further action would not protect the public, was not proportionate nor sufficient given the seriousness of the misconduct and would not meet the public interest concerns.

167. The Committee considered the issue of a financial penalty order. However, it was of the view that such an order was not appropriate, given that it would not protect the public nor meet the public interest concerns. Furthermore, this case did not involve financial motivation or gain, and the Committee did not have any information regarding the Registrant's means in order to satisfy a financial penalty.

168. The Committee considered the Guidance in relation to the imposition of conditions. It was of the view that conditional registration would not be appropriate, as conditions would not be workable in this case. The Committee noted that the misconduct was of a type where conditions could be appropriate, as it involved identifiable clinical areas of practice in need of assessment or retraining, which conditions often seek to address. However, as the Registrant had not engaged with these proceedings and there was no indication that he wished to improve his practice, the Committee could not be reassured that the Registrant would comply with any conditions imposed.

169. Furthermore, conditions would not sufficiently protect the public, as there was no evidence to suggest that the Registrant would abide by them, nor would they address the public interest concerns identified. The Committee concluded that conditions could not be devised which would be appropriate, proportionate, or workable in this case.

170. The Committee next considered suspension and had regard to paragraphs 21.29 to 21.31 of the Guidance. In particular, the Committee considered the list of factors contained within paragraph 21.29 that indicate that a suspension may be appropriate, which are as follows:

Suspension (maximum 12 months)

21.29 This sanction may be appropriate when some, or all, of the following factors are apparent (this list is not exhaustive):

a. A serious instance of misconduct where a lesser sanction is not sufficient.

b. No evidence of harmful deep-seated personality or attitudinal problems.

c. No evidence of repetition of behaviour since incident.

d. The Committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour.

e. In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.

171. The Committee considered that several of the factors listed in paragraph 21.29 of the Guidance were not applicable. The only relevant factors that applied were a) and c). In relation to b), the Committee was of the view that

there might be some evidence of the Registrant having attitudinal problems, given his failure to maintain adequate records from several appointments and his failure to conduct an adequate sight test given his many years of experience. In relation to d), the Committee had found at the impairment stage, that the evidence of insight was highly limited and that the Registrant does pose a significant risk of repeating the behaviour.

172. The Committee was of the view that given the Registrant's lack of insight, remediation and his dis-engagement from these proceedings, there were limited prospects that the Registrant would be in any better position at the end of a period of suspension. Imposing a period of suspension would be in the hope that the Registrant would start to engage. However, on the basis of the information that the Committee currently had, there was no real prospect that he would do so.

173. Furthermore, the Committee concluded that a suspension order was inappropriate to address the public interest concerns that it had identified. The Committee was mindful that this case concerns several incidents of misconduct, raising a range of serious issues regarding the Registrant's fitness to practise, including seriously deficient record-keeping, failing to spot an obvious red-flag clinical sign and misdiagnosis. It considered that a suspension order would not adequately mark the seriousness of the Registrant's conduct, maintain confidence in the profession and declare and uphold proper standards of professional conduct and behaviour.

174. The Committee went on to consider erasure. The Committee was of the view that several of the factors listed in the Guidance at paragraph 21.35 (a)-(h), which lead towards the sanction of erasure being appropriate, applied in this case. Paragraph 21.35 states as follows:

Erasure

21.35 Erasure is likely to be appropriate when the behaviour is fundamentally incompatible with being a registered professional and involves any of the following (this list is not exhaustive):

a. Serious departure from the relevant professional standards as set out in the

Standards of Practice for registrants and the Code of Conduct for business

registrants;

b. Creating or contributing to a risk of harm to individuals (patients or otherwise)

either deliberately, recklessly or through incompetence, and particularly where

there is a continuing risk of harm to patients;

c. Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients;

d. Offences of a sexual nature, including involvement in child pornography;

e. Offences involving violence;

f. Dishonesty (especially where persistent and covered up);

g. Repeated breach of the professional duty of candour, including preventing others from being candid, that present a serious risk to patient safety; or

h. Persistent lack of insight into seriousness of actions or consequences.

175. The Committee was of the view that factors a), b), and h) were all clearly engaged in this case. Furthermore, the Committee noted that several of the other factors listed were for specific types of misconduct, which did not align with the misconduct in this case and so were not applicable. Of the factors that were applicable to the facts of this case, the Committee considered that they were all engaged. The Committee concluded that under the Guidance there were more factors indicating that erasure was the appropriate sanction rather than suspension.

176. The Committee also had regard to paragraph 21.37 of the Guidance, which states that, *"Erasure from the register is appropriate if it is the only means of protecting patients and/or maintaining public confidence in the optical profession."*

177. The Committee determined that given that the nature of the Registrant's conduct was particularly serious and the aggravating factors detailed above, including the Registrant's persistent lack of insight, the misconduct of the Registrant was fundamentally incompatible with being on the Register. The Committee considered that the only proportionate and appropriate sanction in this case that would protect the public was one of erasure and further, any lesser sanction would not uphold standards and would undermine confidence in the profession and the regulator.

178. The Committee therefore ordered that the Registrant be erased from the Register.

Immediate order

179. The Committee heard submissions from Mr Corrie, on behalf of the Council, regarding the imposition of an immediate order. Mr Corrie invited the Committee to exercise its discretion to impose an immediate suspension order under Section 13I of the Opticians Act 1989. He stated that the Committee may consider that there are grounds to do so based upon its earlier findings. He reminded the Committee that if the Registrant appealed, the order for erasure would not come into effect for several months whilst the appeal was pending.

180. Mr Corrie submitted that without an immediate order the public would not be adequately protected and in the light of the Committee's decision to erase the Registrant, as his misconduct was fundamentally incompatible with registration, an immediate order was also in the wider public interest.

181. The Committee accepted the advice of the Legal Adviser, which was that to make an immediate order, the Committee must be satisfied that the statutory test in section 13I of the Opticians Act 1989 is met, i.e. that the making of an order is necessary for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

182. The Committee had regard to the section of the Guidance regarding immediate orders and considered the statutory test, which required that an immediate order had to be necessary to protect members of the public, be otherwise in the public interest or in the best interests of the Registrant.

183. The Committee bore in mind that it had found that the misconduct was serious and there was a high risk of repetition. The Committee was therefore concerned that if no immediate order was made, the Registrant could, despite it appearing that he may have retired, return to practise and repeat the conduct. The Committee therefore concluded that an immediate order was necessary to protect members of the public in this case.

184. The Committee had concluded that erasure was the only appropriate and proportionate sanction in this case. In the circumstances, and given the serious nature of the misconduct, the Committee decided that it was also in the wider public interest that an immediate order be imposed. Accordingly, the Committee imposed an immediate order of suspension.

Revocation of interim order

185. The Committee revoked the existing interim order for suspension.

Chair of the Committee: James Kellock

Signature …… James D. Kellock ….. **Date: 12 December 2023**

Registrant: Robert Fyfe

Signature ……not present ……. **Date: 12 December 2023**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.


General Optical Council